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§19–710.

(a) To qualify for a certificate of authority to operate as a health maintenance organization, an applicant shall satisfy the Commissioner that the applicant will meet the requirements of this section.

(b) The applicant shall conform to the definition of a health maintenance organization.

(c) The applicant shall establish and operate a bona fide health maintenance organization that can provide health care services in the proposed geographic area.

(d) (1) The health maintenance organization shall be actuarially sound.

(2) (i) Except as otherwise provided in this paragraph, the surplus that the health maintenance organization is required to have shall be paid in full.

(ii) The health maintenance organization licensed on or after July 1, 1989 shall have an initial surplus that exceeds the liabilities of the health maintenance organization by at least $1,500,000.

(iii) All health maintenance organizations shall maintain a surplus that exceeds the liabilities of the health maintenance organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the health maintenance organization with the Commissioner.

(iv) No health maintenance organization shall be required to maintain a surplus in excess of a value of $3,000,000.

(3) (i) For the protection of the health maintenance organization's members and creditors, the applicant shall deposit and maintain in trust with the State Treasurer $100,000 in cash or government securities of the type described in § 5–701(b) of the Insurance Article.

(ii) 1. The deposits shall be accepted and held in trust by the State Treasurer in accordance with Title 5, Subtitle 7 of the Insurance Article.

2. For the purpose of applying this subparagraph, a health maintenance organization shall be treated as an insurer.

(4) The Commissioner may waive the surplus and deposit requirements contained in this subsection if the Commissioner is satisfied that:

(i) The health maintenance organization has sufficient net worth and an adequate history of generating net income to assure financial viability for the next year;

(ii) The health maintenance organization's performance and obligations are guaranteed by another person with sufficient net worth and an adequate history of generating net income; or

(iii) The assets of the health maintenance organization or contracts with insurers, governments, providers, or other persons are sufficient to reasonably assure the performance of the health maintenance organization's obligations.

(e) The provisions of Title 4, Subtitle 3 (Risk Based Capital Standards for Insurers) and § 15–604 (Rates for Payments to Hospitals) of the Insurance Article apply to health maintenance organizations in the same manner as they apply to insurers.

(f) The terms of contracts, including any medical assistance program contracts under Title XVIII or Title XIX of the Social Security Act or Title III of the Public Health Service Act, proposed to be made or made with government or private agencies that cover all or part of the cost of subscriptions to provide health care services, facilities, appliances, medicines, or supplies shall be financially sound, based on reasonable actuarial assumptions that the health maintenance organization can meet its obligations to the agencies and their beneficiaries by reason of the health maintenance organization's net worth position, stop loss, reinsurance arrangements with authorized insurers, or other arrangements that are satisfactory to the Commissioner.

(g) (1) The terms of the contracts to be offered to subscribers shall provide that the health care services provided to members of the health maintenance organization will meet reasonable standards of quality of care that are applicable to the geographic area to be served, as approved by the Department.

(2) If a health maintenance organization offers services that are within the scope of practice of a physician and another health care practitioner who is licensed under the Health Occupations Article, the health maintenance organization shall offer those services through other licensed health care

practitioners, where appropriate, as determined by the health maintenance organization.

(h) The procedures for offering health care services and offering and terminating contracts to subscribers may not discriminate unfairly on the basis of age, sex, race, health, or economic status. This requirement does not prohibit:

(1) Reasonable underwriting classifications for establishing contract rates; or

(2) Experience rating.

(i) (1) The terms of the agreements between a health maintenance organization and providers of health services shall contain a "hold harmless" clause.

(2) The hold harmless clause shall provide that the provider may not, under any circumstances, including nonpayment of money due the providers by the health maintenance organization, insolvency of the health maintenance organization, or breach of the provider contract, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, member, enrollee, patient, or any persons other than the health maintenance organization acting on their behalf, for services provided in accordance with the provider contract.

(3) Collection from the subscriber or member of copayments or supplemental charges in accordance with the terms of the subscriber's contract with the health maintenance organization, or charges for services not covered under the subscriber's contract, may be excluded from the hold harmless clause.

(4) Each provider contract shall state that the hold harmless clause will survive the termination of the provider contract, regardless of the cause of termination.

(j) The health maintenance organization shall provide evidence of adequate insurance coverage or an adequate plan for self–insurance to satisfy claims for injuries that may occur from providing health care.

(k) The health maintenance organization shall provide for having its health and medical facilities and services audited and reviewed periodically:

(1) By personnel outside the health maintenance organization who:

(i) Act in a manner that is approved by the Department; and

(ii) Use methods that will assure objective evaluation and keep the identity of patients as confidential as possible;

(2) By the health maintenance organization's own internal quality of care committee audit procedures, if the Department approves the procedures; or

(3) By a professional standards review organization, as described in Title XI of the Social Security Act, that is certified by the Department of Health and Human Services as capable of serving individuals in the area where the health maintenance organization operates who are receiving benefits under Title XVIII or Title XIX of the Social Security Act or Title III of the Public Health Service Act, if the professional standards review organization is acting consistently with its certification.

(l) (1) With the approval of the Department, the health maintenance organization shall provide continuous internal peer review for monitoring and evaluating patient records for:

(i) Quality of care; and

(ii) Overuse and underuse of provider care; and

(2) The health maintenance organization shall meet the requirements of Subtitle 13 of this title and all regulations for the performance of utilization review.

(m) The health maintenance organization shall provide an internal grievance system to resolve adequately any grievances initiated by any of its members, in a manner approved by the Department on matters concerning quality of care and by the Commissioner on all other matters covered by this subtitle, under rules and regulations adopted under this subtitle.

(n) The health maintenance organization shall establish procedures to offer each member an opportunity to participate in matters of policy and operation.

(o) The health maintenance organization shall maintain a health and medical records system that:

(1) Under procedures assuring maximum confidentiality, is readily accessible to authorized persons;

(2) Can accurately document use by each member; and

(3) At a minimum:

(i) Identifies clearly each patient by:

1. Name;

2. Number;

3. Age; and

4. Sex; and

(ii) Shows clearly:

1. The services provided;

2. When the services are provided;

3. Where the services are provided;

4. By whom the services are provided;

5. The diagnosis and prognosis, if appropriate;

6. The treatment;

7. Any drug therapy; and

8. The health status of the patient, if appropriate.

(p) (1) Except as provided in paragraph (3) of this subsection, individual enrollees and subscribers of health maintenance organizations issued certificates of authority to operate in this State shall not be liable to any health care provider for any covered services provided to the enrollee or subscriber.

(2) (i) A health care provider or any representative of a health care provider may not collect or attempt to collect from any subscriber or enrollee any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(ii) A health care provider or any representative of a health care provider may not maintain any action against any subscriber or enrollee to collect or attempt to collect any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(3) Notwithstanding any other provision of this subsection, a health care provider or representative of a health care provider may collect or attempt to collect from a subscriber or enrollee:

(i) Any copayment or coinsurance sums owed by the subscriber or enrollee to a health maintenance organization issued a certificate of authority to operate in this State for covered services provided by the health care provider;

(ii) If Medicare is the primary insurer and a health maintenance organization is the secondary insurer, any amount up to the Medicare approved or limiting amount, as specified under the Social Security Act, that is not owed to the health care provider by Medicare or the health maintenance organization after coordination of benefits has been completed, for Medicare covered services provided to the subscriber or enrollee by the health care provider; or

(iii) Any payment or charges for services that are not covered services.

(q) (1) The Commissioner shall require each health maintenance organization to have an insolvency plan by January 1, 1990 which provides for:

(i) Continuation of benefits to subscribers and enrollees for the duration of the contract period for which premiums have been paid; and

(ii) Continuation of benefits to subscribers or enrollees who are admitted to an inpatient health care facility on the date of insolvency until, the earlier of:

1. The subscriber or enrollee is discharged from the inpatient health care facility; or

2. 365 days.

(2) In determining the adequacy of any insolvency plan, the Commissioner may consider:

(i) The existence of insurance to cover expenses incurred in continuing benefits after an insolvency;

(ii) Provisions in provider contracts obligating providers to continue to provide services to enrollees or subscribers:

1. For the duration of the contract period for which premiums have been made; and

2. If admitted to an inpatient health care facility, until the enrollee or subscriber is discharged or 365 days, whichever occurs first;

(iii) Reserves;

(iv) Letters of credit;

(v) Guarantees; or

(vi) Any other arrangement to assure that benefits are continued in accordance with the provisions of paragraph (1) of this subsection.

(r) Repealed.

(s) (1) In this subsection, "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning services rendered or utilized by a provider under contract with or employed by a health maintenance organization for the provision of health care services by the provider to enrollees or subscribers of the health maintenance organization.

(2) If a health maintenance organization uses a practice profile as a factor in its contract review to evaluate a provider's status on a provider panel, the health maintenance organization shall disclose at the commencement and renewal of the contract and, not more often than annually, upon the request of the provider:

(i) A description of the criteria used to compile the practice profile concerning the provider; and

(ii) The manner in which the practice profile is used to evaluate the provider.

(3) The information provided under this subsection may not be used to create a cause of action.

(4) A health maintenance organization may not terminate a provider contract or provider's employment with the health maintenance organization on the basis of a practice profile without first informing the provider of the findings of the practice profile and the provider specific data underlying those findings.

(t) A health maintenance organization may not by contract, or in any other manner, require a provider to indemnify the health maintenance organization or hold

the health maintenance organization harmless from a coverage decision or negligent act of the health maintenance organization.

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